

I have several points to make: 1. The author describes the individuals' rights to truth and information and maintains that one of the arguments for not telling 'is the uncertainty principle'. This refers to the fact that a doctor can never entirely be sure of the diagnosis or prognosis but yet the author goes on to say that the information conveyed to the patient must be based on knowledge and experience rather than abstract and absolute truth. I find this rather a contradiction.

2. The author states that telling someone she has schizophrenia gives her both an explanation of her behaviour and a reason for it, which in my own opinion is not valid. The term schizophrenia is a label. It is a label which individual psychiatrists, doctors and the general public use. It has different meanings for different people. Even within the group of psychiatrists that practise, for example in the United Kingdom, the term schizophrenia will mean different things to each one.

3. In relation to point 2 I find it difficult to make sense of the paper without any reference to diagnostic criteria such as the Diagnostic and Statistical Manual of Mental Disorder, Third Edition, Revised (DSM-III-R). The author regards other terms such as 'nervous breakdown' and 'problems with your self-confidence' as vague and meaningless phrases. My contention would be that using the term schizophrenia without specifying which diagnostic criteria one is using is equally vague and meaningless in terms of planning for the future and managing the individual's behaviour. For example using the International Classification of Diseases 9th Revision, (ICD-9) an individual can be diagnosed as having schizophrenia on a first episode of psychotic symptoms. At that point informing patients they have schizophrenia would be valid if one was using ICD-9 but would in most psychiatrists' opinion be meaningless in terms of prognosis, outcome and how best to manage the symptoms or behaviour. In contrast, using DSM-III-R, the diagnosis of schizophrenia cannot be made until an individual has had continuous

symptoms for over six months. Informing a patient that she has a diagnosis of schizophrenia under DSM-III-R, is relatively more meaningful in terms of prognosis etc.

4. It would be my contention that the diagnosis, ie the label, is completely irrelevant. What is relevant is the level of distress and disruption in the individual's life which is caused by whatever symptoms she is experiencing. These are problems. In fact the patient may not be aware or fully aware of the results in her general life of having these symptoms. It would be my contention that it is this sort of information which needs to be imparted to the patient.

5. The author describes psychiatrists as lying to patients through an act of omission by not telling them their diagnosis. The author very rightly mentions the social effects of being labelled schizophrenic, and that being given the label of schizophrenia may do harm within the individual's social setting. But she feels that the concern for its harmful social affects are out of proportion as the individual is under no obligation to share the information of her diagnosis with others but yet in the same paper she uses the example of an individual who heard on the television that a certain depot injection was used for schizophrenics and psychopaths. That individual then made the assumption that he had schizophrenia. Also, the author in her case history very clearly describes a young man who had a diagnosis of schizophrenia but had not been informed of it, who then subsequently found out his diagnosis through the Job Centre. This highlights one of the issues involved which is that once one has this label of schizophrenia agencies have access to one's medical records and that once the label is used it in effect cannot be reversed so although the patient himself may not want to share the information about his diagnosis with other people, other people may in fact discover the label through independent means.

I must say, after these criticisms, that I agree with the main gist of Dr Atkinson's paper that patients have a right to be informed. I think the crux of

the matter is, or rather the question to be asked is, what exactly is it that they need to know? The studies which she has quoted regarding the prognostic factors associated with schizophrenia she describes as 'very real evidence we have regarding outcome and particular variables'. It must be stated that these variables have been derived through statistical analysis and as such one cannot and should not generalise them to an individual patient and that using these variables does not give one *carte blanche* to predict the future.

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Killing and voluntary euthanasia

SIR

In the **Words** item by Jean Davies, entitled Raping and making love are different concepts: so are killing and voluntary euthanasia (1988;14:148-149), I like the analogy of murder v voluntary euthanasia with rape v making love, since rape is likewise without consideration for the victim.

However, I cannot agree that the basic distinction between murder and voluntary euthanasia is killing rather than helping to die. In carrying out euthanasia it may be necessary, when natural death is not imminent, actually to kill - for example if the patient is incapable of any active participation, and certainly in the case of infant euthanasia - but, provided the killing were a compassionate act, carried out for the sake of the patient and for sufficient reason, it would surely still be euthanasia (whether voluntary or non-voluntary), not murder. The word 'kill' may well have unfortunate associations, but that does not justify replacing it by less apposite words.

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